Exhibit A
Scope of Work

Scope of Work

The Contractor will objectively measure the performance of managed care plans (plans) contracted with the Department to provide Medi-Cal covered services to Medi-Cal eligible individuals. Such objective measurement is intended to provide an in-depth analysis of the quality of the health care provided by the plans, as well as to evaluate the effectiveness of the plans' internal quality improvement systems.

The Department intends that the selected Contractor conduct independent reviews of contracted plans for quality, timeliness of services and access to services provided or arranged for by contracting plans. The reviews must include an annual assessment of specified quality of care indicators and evaluation of the plans' quality improvement projects. Additionally, the Contractor will prepare an annual report for each plan that comprehensively assesses the overall performance of the plan to provide services to Medi-Cal beneficiaries.

The Contractor will prepare an analysis and recommendations concerning methodologies for identifying and measuring superior performance. The Contractor will also prepare an annual statewide performance evaluation report to include conclusions drawn from the quality reviews, as well as recommendations for improvement in the external quality review program.

As part of the Quality Improvement Program, the Contractor will be expected to work with the Department and the managed care plans in the selection and implementation of collaborative quality improvement initiatives. The Contractor will also be expected to coordinate and facilitate an annual Quality Improvement Conference, assume an integral role in the Department's Quality Improvement Workgroup, and participate in other Departmental meetings that have a direct impact on the quality improvement program.

The Department may elect to continue use of a bi-annual consumer satisfaction survey as part of the Quality Improvement Program's monitoring efforts. In this case, the Contractor will be required to conduct the survey and analyze the results for each contracted health plan. The Contractor may also be requested to provide Special Consultative Services to the Department in the development and analysis of activities undertaken by the Department as part of the Quality Improvement Program.

Throughout the term of the contract, the Contractor is expected to provide recommendations and technical assistance in support of improvements within the plans' service delivery systems, as well as to the Medi-Cal Managed Care Quality Improvement Program.

The Contractor agrees to provide to the Department of Health Services (DHS) the services described herein:

A. Audit and Reporting of External Accountability Set Performance Measures

1. General Description:

The Department has selected or developed a set of performance measures to evaluate the quality of care delivered by contracted plans on an annual basis. These measures are collectively known as the External Accountability Set (EAS) and consist of selected Health Plan Employer Data and Information Set (HEDIS®) measures and Department-developed performance measures.

a. Health Plan Employer Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to allow comparisons of the performance of managed care plans. HEDIS is updated annually to include new measures, as well as to refine existing measures. In order to maintain a quality improvement program that is flexible and responsive to the needs of the Medi-Cal beneficiaries, the Department may replace or rotate HEDIS performance measures. Therefore, the External Accountability Set HEDIS measures may vary from year to year. During contract year one, it is expected that the External Accountability Set will include seven (7) HEDIS measures. Up to two additional HEDIS measures may be added to the contract requirements during either contract year two or year ~~three.~~ three.

The plans must report the audited results of Department-selected HEDIS measures as part of the External Accountability Set. In doing so, the plans must comply with Department requirements and the HEDIS specifications that are applicable to the reporting period. During each contract year, plan performance will be compared at both the county and plan level. Therefore, plans must calculate and report all selected HEDIS measures for each county in which they operate.[1] The Department may also require two (2) of the plans to calculate and report HEDIS rates for each of their respective subcontracting plans, in addition to reporting HEDIS rates at the county level. This would result in analysis of HEDIS rates for seven (7) health plans under subcontract to two (2) Department-contracted plans.

b. Department-Developed Performance Measures

In addition to the NCQA-developed HEDIS performance measures, the Department develops and implements its own performance measures as part of the External Accountability Set. To date, the Department has developed two such performance measures, Blood Lead Screening and Use of Beta Agonist in Asthma Treatment. The

[1] In order to calculate and analyze EAS performance measure rates at the county and/or subcontractor level, plans must submit sufficient data to calculate each measure for each county and/or subcontractor. For example, a plan operating in five (5) counties will calculate five (5) HEDIS scores per measure. The EQRO Contractor is expected, as part of the Compliance Audit, to verify the source codes for each measure for each of the five counties. The results of the audit, and final rates, will be presented in the plan-specific final reports.

Department may request assistance from the Contractor in the refinement of these performance measures during the term of this contract. Additionally, the Department may request assistance from the Contractor in modifying performance measures in use with other entities, but that require refinement for use with the Medi-Cal managed care population. Should the Department require such assistance, the Department will arrange for these services under the terms of engagement for Special Consultative Services, as set forth in Section J. As with the HEDIS measures, plans will be required to report the audited results for Department-developed measures at the county level for all counties in which they operate, as well as at the plan level.[1] Additionally, the Department may elect to require reporting of all Department-developed performance measures for each of seven (7) plans under subcontract to two (2) of the health plans.

2. Required Activities:

a. External Accountability Set Compliance Audits

On an annual basis, the Contractor will conduct on-site, county-specific External Accountability Set Compliance Audits of all selected performance measures for all contracted plans. The audits are to include a review of the health plans' information and reporting systems, as well as an evaluation of the plans' methodologies for calculating performance measure rates. In order to perform analyses at the county level, the Contractor will be required to verify source codes for each measure for each county of operation. Currently, there are forty-three (43) county-level analyses that would need to be performed as part of the annual External Accountability Set Compliance Audits. (Please see ~~Appendix 3~~Appendix 3 for a listing of health plans by contract, county, and subcontracting plans.) The Department anticipates that one (1) additional county will be added during the term of this contract. Should the Department elect to require two (2) of the health plans to report performance measure rates for each of their respective subcontracting plans, the total number of analyses to be performed would be fifty-one (51). The Contractor is to conduct all audits in accordance with a standardized audit methodology as approved by the NCQA.

3. Reporting Requirements:

a. Plan-Specific Reports

1) Preliminary Report of the External Accountability Set Compliance Audits

Upon completion of each on-site audit, the Contractor will produce a Preliminary Audit Report for each plan detailing the results of the compliance audit for the External Accountability Set.[2] This report is to include the results of the audit for tracking and reporting capabilities for HEDIS and Department-developed

[2] As the scope of reporting includes information about Department-developed measures, and therefore differs from that for NCQA pursuant to their reporting specifications, it is the Contractor's responsibility to meet all NCQA reporting requirements separate and apart from those reporting requirements as set forth by the Department in this contract. Accordingly, the Contractor will need to prepare separate HEDIS Compliance Audit reports for submission to NCQA that do not disclose information regarding Department-developed performance measures.

performance measures as performed at the county and plan level. Should the Department elect to require the Contractor to perform analyses for seven (7) subcontracting plans, the Preliminary Reports must reflect the results of the audit at the county, plan, and subcontractor level. In total, the Contractor will produce twenty-two (22) plan reports. If a plan's information systems and/or reporting methodologies differ by county or for subcontracted plans, the Contractor will be required to identify the results of this portion of the audit for each county and subcontractor within the plan-specific report. Otherwise, it is expected that the Preliminary Report findings concerning the plan's information systems will be reflective of the entire health plan, including all associated counties of operation, and plan subcontractors, if required by the Department. The Contractor will be required to deliver each plan-specific report to the Department no later than two (2) weeks after completion of the on-site audit.

2) Final Report of the External Accountability Set Compliance Audits

The Contractor will produce a Final Audit Report for each plan that identifies the findings of the audit, all corrective actions recommended and corrective actions taken to eliminate errors found during the audit, and the resulting rates for each of the External Accountability Set performance measures.[2], [3] If a plan's information systems and/or reporting methodologies differ by county or for subcontracted plans, the Contractor will be required to identify the results of this portion of the audit for each county and subcontractor within the plan-specific report. Otherwise, it is expected that the Final Report findings concerning the plan's information systems will be reflective of the entire health plan, including all associated counties of operation, and plan subcontractors, if required by the Department. For those plans operating in multiple counties, the results of the audit and the performance measure rates are to be presented at the county and plan level. Should the Department elect to require the Contractor to perform audits for seven (7) subcontracting plans, the Final Audit Reports are to reflect the results of the audit and performance measure rates at the county, plan, and subcontractor level. All final plan-specific reports will be due to the Department by June 15 of each contract year, or such later date as the Department ~~specifies.~~
specifies.

b. Aggregate Reports

Upon completion of all compliance audits, and after verification of the final reported compliance rates for all contracted Plans, the Contractor will develop two separate summary reports that identify significant trends and systemic issues among the contracted Medi-Cal managed care plans for (1) HEDIS performance measures and (2) Department-developed performance measures. The reports are to provide comprehensive analyses of the performance of the Medi-Cal managed care system in delivering care, as measured by the EAS measures.

The reports are to include detailed findings, analysis and recommendations to the

[3] Pursuant to the NCQA methodology, HEDIS rates are to be calculated by the plans and verified by the Contractor. The rates for Department-developed performance measures will be calculated by the Contractor.

Department concerning:

i. Information system capabilities;

ii. Reporting methods;

iii. Medical record abstraction tools and processes;

iv. Calculation of rates of the performance measures; and

v. Areas requiring improvement.

With respect to the performance measure rates, the reports must address, at a minimum:

i) A comparison of each plans' rate for each reported measure with each of the other contracted plans in their respective counties, at the plan level and subcontractor level;

ii) A comparison of each plans' rate for each reported measure with the average rate for that measure for each plan model type;

iii) A comparison of each plans', and subcontractors' rate with the Medi-Cal Managed Care average (i.e. the average of all contracted plans) for each measure;

iv) A comparison of each plans', and subcontractors' rate to appropriate benchmarks including, but not limited to the national Medicaid average, commercial plan averages, and Healthy Families program rates for each measure, as available;

v) Identification of potential areas for targeted improvement efforts;

vi) Performance trends for each measure across all previous reporting years by each plan and subcontractor;

vii) Specific recommendations to the Department for overall improvement in External Accountability Set performance rates.

As part of the analyses, the Contractor is expected to present and discuss the statistical significance of the rate variance between plans in order to establish the value of the findings.

The draft aggregate reports will be due to the Department by August 1, or such later date as specified by the Department, of each contract year. The final aggregate reports must be delivered to the Department by September 15, or such later date as specified by the Contractor, of each contract year.

[4] Reporting at the subcontractor level will be at the discretion of the Department and consistent with the level of analysis performed at the time of the EAS Compliance Audit.

4. Bidding Specifications:

For each contract year, the Proposer must provide two complete set of bids, one for the core set of deliverables, one for the enhanced set of deliverables.

a. Core Deliverables

The first set of bids should be based upon county-level analyses and should include the cost for preparing (1) Preliminary Reports of the External Accountability Set Compliance Audit; (2) Final Reports of the External Accountability Set Compliance Audit; and (3) the each of two aggregate reports. All costs associated with performance of the audits must be calculated into the bids for the reports. There will be no separate remuneration for performance of the audits.

b. Enhanced Deliverables

The second set of bids are for the Enhanced Deliverables which include the county and subcontractor level analyses. The Proposer must provide bids for the Preliminary and Final reports. The bids provided for aggregate reports, as core deliverables, will be used for evaluation purposes regardless of the level of analysis ultimately selected by the Department. All costs associated with performance of the audits must be calculated into the bids for the reports. There will be no separate remuneration for performance of the audits.

Bids for both the Core and Enhanced Deliverables are to be based upon the assumptions that, in contract year one, the External Accountability Set will consist of seven (7) HEDIS measures and two (2) Department-developed measures. Beginning in contract year two (2), and each year thereafter, the EAS will include nine (9) HEDIS measures and two (2) Department-developed performance measures.

Costs associated with consultative services provided to the Department as required for the refinement and/or modification of EAS performance measures will be paid under the terms of engagement for Special Consultative Services.

B. Evaluation of Quality Improvement Projects (QIPs)

1. General Description:

Quality Improvement Projects (QIPs) are studies performed by the plans to improve the quality of services delivered in areas with specific identified problems. All plans are contractually required to conduct four (4) QIPs and to evaluate the effectiveness of systematic interventions to improve performance. Specifically, each plan is required to conduct at least one (1) plan-specific QIP, as well as to participate in up to three (3) additional collaborative QIPs including a statewide Medi-Cal Managed Care collaborative project. As part of the four (4) projects, each plan is required to conduct or participate in at least one non-clinical QIP. When a QIP has been completed, the plan must initiate a new project, always maintaining four active projects. Plans with multiple contracts may select the same QIP topic for all of their contracts. However, QIPs that are designed to cover the entirety of a multiple county contract may require proportional sampling or other sampling of

all counties as required to evaluate geographic differences. Measurement of improvement must be determined for each contract individually. Plans are not required to use HEDIS indicator specifications for the projects, but may elect to do so.

The statewide collaborative QIP is jointly selected by the Department and participants of the Quality Improvement Workgroup based upon a recognized systemic need for improvement. During calendar year 2000, the Department and plans selected the HEDIS measure "Chlamydia Screening Rates in Women" as the statewide collaborative study. In 2001, the QIP was modified to focus on interventions to increase chlamydia screening rates. This measure will be incorporated into the External Accountability Set beginning contract year one, at which time the Department will select a new topic. The Contractor, in consultation with the Department and participants of the Quality Improvement Workgroup, will assist in the selection and implementation of a new statewide QIP based upon an assessment of the Medi-Cal population's health needs.

Non-statewide collaborative QIPs ("small group QIPs") may be regionally based (e.g. San Diego health plans), interest based (e.g. diabetes management), or plan model based (e.g. GMC plans) and must be conducted by a minimum of four (4) health plans.

Each QIP is expected to follow four phases that must be completed within 24 months. The plan is required to produce a report, using the NCQA Quality Improvement form, upon completion of each phase of a QIP. The four phases are:

a. Phase I - This phase requires the plan to:

   1) Select a clinical or non-clinical area of study based upon analysis of the need for and feasibility of the project;

   2) Identify the project's goals and objectives;

   3) Determine what questions and/or hypotheses the project will answer or test;

   4) Determine the performance measures and/or quality indicators to be used to measure baseline rates;

   5) Develop the project timeline or work plan; and

   6) Develop the specific project methodology to achieve the study objectives.

b. Phase II - This phase requires the plan to:

   1) Collect and analyze baseline data; and

   2) Design interventions to achieve improvement over baseline findings, based upon the review of research literature and analysis and conclusions drawn from the baseline data.

c. Phase III - This phase requires the plan to:

1) Implement interventions;

2) Conduct a re-measurement after completion of a period of time following initiation of the interventions. This time period will be agreed upon by the Department and the health plan;

3) Analyze remeasurement data and document improvement in one or more of the performance measure rates or determine why implementation of interventions failed to achieve improvement; and

4) Determine revisions/refinements to the interventions necessary before a second remeasurement of data and performance rates.

d. Phase IV - This phase requires the plan to:

1) Conduct a second re-measurement demonstrating continued improvement in performance measure rate(s) or indicators of quality, or achievement of improvement for the first time as a result of revisions/refinements to the interventions made as a result of the first remeasurement; and

2) Design and implement an ongoing process to ensure that the demonstrated improvement can be maintained over time.

2. Required Activities:

a. During the first six months of contract year one, the Contractor will develop and recommend evaluation criteria to be applied in the assessment of QIPs. As an example, Phase One criteria may include an assessment as to whether the proposed QIP addresses a significant problem; whether the plan has performed a literature review to research appropriate benchmarks and performance standards; whether the plan has adequately researched prior studies regarding interventions and the effectiveness of those interventions; whether the project involves adequate stakeholder participation; whether the plan has conducted a feasibility analysis to determine potential barriers to improvement.

b. During contract year one, the Department, in consultation with the Contractor and QI Workgroup will identify and prioritize three (3) potential statewide collaborative topics based upon an assessment of the Medi-Cal populations' health needs. Upon selection of the statewide collaborative, the Contractor will lead the development of methodologies for baseline measurement and remeasurement, as well as identification of interventions and protocol for implementation of those interventions.[5] By the end of the first contract year, the Contractor will complete the baseline measurement for each plan and report the findings in an aggregate report. The Department may also request that the Contractor assist the Department in researching sources for external funding for performance of collaborative studies and in writing grant proposals to obtain such funding.

c. During contract year two, the Contractor will provide technical assistance to the Plans in implementation of the selected interventions for the statewide collaborative. The

[5] For those collaborative QIPs based upon HEDIS measures, the baseline measurements used may be the HEDIS rates.

Contractor will provide a status report identifying significant issues that may impact the results of the study, problems in implementation, identified solutions, and best practices. By the end of contract year two, the Contractor will perform a remeasurement for each plan and report the findings in an aggregate report.

d. During contract year three, the Contractor will work in consultation with the Department and QI Workgroup to select a new statewide collaborative quality improvement project. As noted above for contract year one, the Contractor is expected to lead the development of the methodologies for baseline measurement and remeasurement, as well as identification of interventions and protocol for implementation of those interventions. By the end of contract year three, the Contractor will complete the baseline measurement for the statewide collaborative.[6]

e. Within two weeks of receipt, the Contractor will review and evaluate each proposed QIP submitted by the plans for either the individual or small group QIPs. The Contractor will provide an assessment and recommendation as to the appropriateness of the project topic and study methodology, including the adequacy of performance measures/indicators chosen. The Contractor is to deliver the evaluation to the health plan(s) and Department simultaneously.

f. At the completion of each phase of QIP activity, each plan must submit a report summarizing the results of phase activities. The Contractor will review and evaluate reports submitted by the plans for completeness of the reporting process and adequacy of the conduct of the study. The Contractor will review the processes used by the plans to measure and remeasure for improvement. If a plan does not achieve improvement, the Contractor shall evaluate the plan's analysis as to the causes for failure to achieve the desired improvement and develop recommendations for a remedial plan to improve results prior to remeasurement. The Contractor will deliver, within two weeks of receipt of a plan's phase-end report, a written evaluation of the QIP phase. This evaluation is to be delivered to the health plan(s) and Department simultaneously.

g. The Contractor will issue quarterly status reports on all plan-specific and small group QIPs as noted below.

3. Reporting Requirements:

a. Report of QIP Evaluation Criteria

By June 15 of contract year one, or such later date as the Department requires, the Contractor shall issue a report of recommended evaluation criteria for assessment of each phase of QIPs.

b. Quarterly Status Reports for Plan-specific and Small Group QIPs

Beginning April 30 of contract year one, or such later date as specified by the Department, and for each subsequent quarter of each contract year, the Contractor will

[6] Should the statewide collaborative initiated during contract year one continue into contract year three, a new statewide collaborative QIP may not be selected. Under such circumstances, the Contractor will be relieved of responsibilities concerning the development and implementation of measurement methodologies or interventions for a new statewide collaborative QIP until such time as the existing statewide collaborative QIP is completed.

issue quarterly status reports to the Department which track the status of all plan-specific and small group QIPs. The reports must identify potential and/or significant issues experienced by the plan during the most recent phase, as well as corrective actions recommended and corrective actions taken by the plan in remediation of identified problems. In noting a plan's successful completion of a QIP phase, the Quarterly Report should also identify key findings and best practices that contributed to the QIP progress.

c. Initial QIP Evaluations for Plan-specific and Small Group QIPs

Within two weeks of receipt of a plan's submission of a proposed QIP, the Contractor will issue an evaluation to the plan and Department. The evaluation is to include either a recommendation for the plan to proceed or required corrective actions.

d. Phase-end QIP Evaluations for Plan-specific and Small Group QIPs

Within two weeks of receipt of a plan's report of QIP phase completion, the Contractor will issue an evaluation to the plan and Department. The evaluation is to include either a recommendation for the plan to proceed or required corrective actions.

e. Report of Baseline Measurement for the Statewide Collaborative QIP

By September 30 of contract year one and contract year three, or such later date as specified by the Department, the Contractor shall prepare an aggregate report of results of the statewide collaborative baseline measurement for each plan. The report is to include a description of the study, the basis of selection of the study, and the anticipated results after implementation of the interventions.

f. Status Report of the Statewide Collaborative QIP

By March 30 of contract year two, or such later date as specified by the Department, the Contractor shall prepare a status report of the statewide collaborative study. This report should identify any key issues that may impact the results of the remeasurement, as well as any refinements made to the study while in progress.

g. Report of Remeasurement Results for the Statewide Collaborative QIP

By September 30 of contract year two, or such later date as specified by the Department, the Contractor shall prepare a report that analyzes the results of the remeasurement for each plan. If the desired results are not achieved after implementation of the selected interventions, the Contractor is to evaluate the causes for failure, including flaws in the study methodology. The report is also to include recommendations for improvement to the study.

4. Bidding Specifications:

a. For contract year one, the Proposer must bid the following:

1) The cost of the Report of QIP Evaluation Criteria;

2) The cost of the Report of Baseline Measurement for the Statewide Collaborative QIP; and

3) The cost of the Quarterly Status Reports for Plan-Specific and Small Group QIPs.

The bid for the Report of Baseline Measurement for the Statewide Collaborative QIP must be inclusive of all costs associated with assisting the Department and the plans in development and/or identification of collaborative initiative topics, measurement and remeasurement methodologies, potential interventions, and protocol for implementation of interventions. There will be no separate remuneration for assisting the Department in selection and implementation of the Statewide QIP.

Costs associated with consultative services provided to the Department as requested for investigation of funding sources and/or grant writing will be paid under the terms of engagement for Special Consultative Services.

During each contract year, including contract year one, the Contractor is required to prepare Initial QIP Evaluations and Phase-end QIP Evaluations for individual plan and small group QIPs. The Contractor is expected to condense this information to produce the Quarterly Status Reports for Plan-Specific and Small Group QIPs. Costs associated with the performance of the Initial and Phase-end Evaluations must be calculated into the bid for Quarterly Status Reports. There will be no separate remuneration for Initial or Phase-End QIP Evaluations.

b. For contract year two, the Proposer must provide bids for the following:

1) The cost of the Quarterly Status Report of QIPs;

2) The cost of the Status Report of the Statewide Collaborative QIP; and

3) The cost of the Report of Remeasurement Results for the Statewide Collaborative QIP.

As noted above, all costs associated with providing assistance to the Department and the plans in implementation of the Statewide QIP must be calculated into the bids for the Status Report and QIP Remeasurement Report for the Statewide Collaborative. There will be no separate remuneration for assisting the Department or plans in the execution of the Statewide QIP.

c. For contract year three, the Proposer must provide bids for the following:

1) The cost of the Quarterly Status Reports for Plan-specific and Small Group QIPs; and

2) The cost of the Report of Baseline Measurement for the second Statewide Collaborative QIP.

As noted above, all costs associated with providing technical assistance to the plans and the Department must be calculated into the bid for the reports. There will no separate remuneration for such assistance.

d. For contract year four (extension year one), the Proposer must provide bids for the following:

1) The cost of the Quarterly Status Reports for Plan-specific and Small Group QIPs;

2) The cost of the Status Report of the Statewide Collaborative QIP; and

3) The cost of the Report of Remeasurement Results for the second Statewide Collaborative QIP.

e. For contract year five (extension year two), the Proposer must provide bids for the following:

1) The cost of the Quarterly Status Reports for Plan-specific and Small Group QIPs; and

2) The cost of the Report of Baseline Measurement for the third Statewide Collaborative QIP.

C. Defining Superior Performance

1. General Description:

The Department intends to develop and implement incentives for superior performance in the delivery of health care services. The goals of this effort are to reward plans that have demonstrated an excellence in focused areas and to promote continuous quality improvement. The Contractor will develop a methodology for identification and evaluation of superior performance as measured by each of the Quality Improvement Program variables (i.e. External Accountability Set measures; Consumer Satisfaction Survey results; QIPs).

2. Required Activities:

The Contractor will define superior performance and identify methodologies for applying the proposed definition in evaluation of plan performance. As part of the activity, the Contractor is expected to investigate and present industry methodologies for benchmarking, as well as to analyze and recommend strategies for weighting performance variables.

3. Reporting Requirements:

a. Interim Report

By June 30 of contract year one, or such later date as specified by the Department, the Contractor shall prepare an interim report that documents approaches for identifying and evaluating superior performance. Specifically, the report should identify definitions for "superior performance", the standards by which plans may be measured for superior performance, and methodologies for rating plan performance across QI Program variables.

b. Final Report

By September 30 of contract year one, or such later date as specified by the Department,

the Contractor shall submit a final report that presents recommended definitions and methodologies for applying those definitions in evaluation of superior performance.

4. Bidding Specifications:

For contract year one only, the Proposer is required to submit a bid for the cost of the Interim Report and the cost of the Final Report Defining Superior Performance. The bids must be inclusive of all costs associated with required research and analysis, as well as the production of the reports.

D. Performance Evaluations

1. General Description:

In order to develop a profile of each plan with respect to performance across quality indicators, the Contractor will prepare annual plan-specific evaluations, as well as an annual assessment of the managed care system as a whole. The Contractor will be expected to identify and assess trends over time, as well as recommend intervention strategies for identified performance issues.

2. Required Activities:

The Contractor shall provide an annual analysis of each plan's performance, at the contract level, and across quality measures (i.e. HEDIS; Department-developed performance measures; QIPs; and Consumer Satisfaction Surveys, if required by the Department). Additionally, the Contractor will prepare an annual analysis of the managed care plans in aggregate. The reports shall include, at a minimum:

a. An analysis of performance results for each quality measure;

b. An analysis of performance results for each quality measure across plan models;

c. A comparison of Medi-Cal managed care plans' performance results for each quality measure relative to industry benchmarks including the national Medicaid averages; commercial plan averages; Healthy People 2010 target rates; and the California Healthy Families program;

d. Recommendations for intervention activities to improve plan and system-wide performance.

As part of the analysis, the Contractor will be expected to include a review of the Department's internal monitoring activity findings including audit reports, utilization statistics, and plan profiles.

3. Reporting Requirements:

a. Plan-Specific Evaluation Reports

By October 30 of each year, or such later date as specified by the Department, the

Contractor shall issue to the Department evaluation reports for each of the contracted managed care plans with analysis at the contract level.

b. Medi-Cal Managed Care Evaluation Report

By November 30 of each year, or such later date as specified by the Department, the Contractor shall issue to the Department an aggregate evaluation report.

4. Bidding Specifications:

For each contract year, the Proposer is required to bid the costs for preparing the plan-specific reports and an aggregate report. The bids must be inclusive of all costs associated with the analysis of data and production of the reports.

E. Consumer Satisfaction Survey

1. General Description:

As part of the process of evaluating the quality of health care services provided by managed care plans, the Department has, during the term of the first EQRO contract, conducted consumer satisfaction surveys to assess the perceptions and experiences of Medi-Cal plan members regarding the services they have received. During contract years one and three, the Contractor may be required to conduct a consumer satisfaction survey using the Consumer Assessment of Health Plan Survey (CAHPS®), version 2.0H or the revised 2.0H developed by the NCQA. The revised version 2.0H includes a questionnaire targeted at children with special health care needs.[7] Should the Department elect to continue using consumer satisfaction surveys to measure plan performance, the results of the surveys will be used to facilitate comparisons across plans, plan models, and two-plan model types (e.g. geographic managed care plans; county-organized health systems; commercial plans; local initiatives), identify potential areas for improvement, and assist plans in developing intervention strategies targeted at problem areas.

2. Required Activities:

Assuming that the Department continues to use consumer satisfaction surveys as a component of the Quality Improvement Program, the Contractor would be required to satisfactorily complete the following activities:

a. During the first year of the contract, the Contractor will conduct a consumer satisfaction survey, using CAHPS 2.0H or the revised version 2.0H. The survey must be conducted for each plan, at the contract level, and must include child and adult versions. Currently the State holds thirty (30) separate contracts with twenty-two (22) plans in California. The survey is to be performed in English and Spanish.

b. During contract years three and five (extension year two), the Contractor will conduct a consumer satisfaction survey, using CAHPS 2.0H, the revised version 2.0H, or the most current version of CAHPS available at that time. The Contractor will be required to

[7] The Department will determine which survey version, if any, will be used after completion of the Department's cost-benefit analysis based, in part, upon bidders' cost proposals.

conduct the survey in English and Spanish and may be asked to use three additional languages. Translations of the CAHPS survey are currently available in Vietnamese, Korean, and Chinese. The Contractor will be responsible for obtaining appropriately translated tools for any follow-up activities performed.

3. Reporting Requirements:

a. Plan-Specific Reports of Consumer Satisfaction Survey Results

Upon completion of the consumer satisfaction survey and verification of the final reported results, the Contractor will produce a report for each plan, analyzing the survey findings at the contract level. The Contractor will prepare the reports for each plan in accordance with NCQA established procedures. All plan-specific reports will be due to the Department by August 15 of contract years one and three, or such later date as specified by the Department.

b. Summary Report of Consumer Satisfaction Survey Results

The Contractor will prepare a summary report that analyzes the CAHPS consumer satisfaction survey results for all plans, at the contract level. The report is to include recommendations for correction of deficiencies found during performance of the surveys, as well as for improvement of overall reporting and calculated results. Additionally, the Department may request that the Contractor prepare the analysis to adjust for demographic differences among plans in comparing plan results. The draft Summary Report will be due to the Department by August 15 of contract years one and three, or such later date as specified by the Department. The final Summary Report must be delivered to the Department by September 30 of contract years one and three, or such later date as specified by the Department.

4. Bidding Specifications:

a. For contract year one, the Proposer must bid the following:

1) The cost of preparing plan-specific reports and an aggregate report based upon use of the CAHPS 2.0H survey tool in English and Spanish; and

2) The cost of preparing plan-specific reports and an aggregate report based upon use of the Revised CAHPS 2.0H survey tool in English and Spanish.

The bids must be inclusive of all costs associated with performance of the survey, including any follow-up activities undertaken to increase response rates; analysis of survey data; and production of the reports.

b. For contract years three and five (extension year two), the Proposer is required to present four (4) sets of bids:

1) The cost of preparing plan-specific reports and an aggregate report based upon use of the CAHPS 2.0H survey tool in English and Spanish;

2) The cost of preparing plan-specific reports and an aggregate report based upon use of the Revised CAHPS 2.0H survey tool in English and Spanish;

3) The cost of preparing plan-specific reports and an aggregate report based upon use of the Revised CAHPS 2.0H survey tool in five (5) languages; and

4) The cost of preparing plan-specific reports and an aggregate report based upon use of the Revised CAHPS 2.0H survey tool in five (5) languages.

The bids must be inclusive of all costs associated with performance of the survey, including any follow-up activities undertaken to increase response rates; analysis of survey data; and production of the reports.

F. Annual Quality Improvement Conference

1. General Description:

During January 2004 and January 2005, the Contractor will conduct a one-day, annual quality improvement conference for plans, Department staff, the Center for Medicare and Medicaid Services (CMS), and other invited organizations and individuals. The goal of the Annual Quality Improvement Conference is to bring together managed care professionals and quality improvement experts whose mutual objective is to make a difference in the quality of care delivered to plan members. This conference will present up-to-date, practical information regarding Quality Improvement issues and best practices as they affect the managed care environment. The Contractor may establish a committee that includes plan representatives, as well as representatives from the Department, to design the annual quality improvement conference.

2. Required Activities:

In planning the conference, the contractor must arrange for:

a. Keynote speakers;

b. Attendance/participation of nationally recognized speakers;

c. Conference facilities and audio/visual equipment, as appropriate;

d. Conference documents including registration materials and session handouts;

e. A luncheon, as well as morning and afternoon snacks;

f. Honorariums and travel costs;

g. Availability of continuing education units; and

h. Post-conference evaluation and recommendations for future conferences.

By September 15, 2003 and each September 15 thereafter, the Contractor must submit a draft agenda for the following January conference. The conferences are to be conducted in

Sacramento during the month of January beginning in 2004. Arrangements should be based upon an estimated attendance of approximately 250 attendees.

3. **Bidding Specifications:**

   For each contract year beginning in 2004, the Proposer must bid the cost of the conference, inclusive of all costs associated with the planning, coordination, and presentation of the event, (e.g. facility rental, food, speakers' travel costs and honorariums as noted above in Section F.2). There will be no separate remuneration for costs incurred during contract year one in planning the 2004 QI Conference.

G. Attendance at Specified Meetings

The Department's Medi-Cal Managed Care Division (MMCD) has established a number of workgroups that assist the Department in developing and implementing performance measures, clinical standards, and policy. The Contractor will be expected to participate in specific meetings and workgroups as follows**:**

1. **Quality Improvement Workgroup:** The Contractor will participate in all regularly scheduled meetings of MMCD's Quality Improvement workgroup. The Quality Improvement workgroup, consisting of representatives from the EQRO Contractor, plan Quality Improvement or Medical Director staff, and the Department, meets for a full day, approximately eight (8) times per year. The purpose of this workgroup is to advise MMCD on overall quality improvement policies and QI system standards. The Contractor will present materials, conduct appropriate research on selected issues, propose strategies and methodologies for problem resolution or system improvement and otherwise facilitate the work of this workgroup. The Contractor will be required to be physically present at five (5) of the meetings, which will be determined by the Department. The remaining meetings may be attended via telephonic conferencing**.**

2. **Medical Directors' Meetings:** The Contractor will participate in regularly scheduled Medical Directors' meetings which are held for a full day, approximately six (6) times per year. All plan Medical Directors and the Directors of their Quality Improvement programs are invited to attend these meetings. The purpose of this forum is for the Department to discuss important medical policy, quality improvement and key operational issues with the Medical Directors and key plan staff. The Contractor will be required to be physically present at two (2) of the meetings which will be determined by the Department. The remaining meetings may be attended via telephonic conferencing as requested by the Department.

3. **Encounter Data Workgroup:** The Contractor will participate in regularly scheduled meetings of the Encounter Data workgroup, as required by the Department. This workgroup includes representatives from the operations, information systems and clinical areas of the plans and the Department and meets approximately seven (7) times per year for a full-day meeting. The purpose of the workgroup is to focus appropriate attention and resources on improving the accuracy, timeliness, completeness and validity of the encounter data submitted by the plans to the Department. This workgroup also discusses appropriate presentation and usage of the data housed at the Department and assists the Department in setting minimum standards for data submission. The Contractor is not expected to attend in

person, but will participate via telephonic conferencing.

4. Regularly Scheduled Conference Calls:

The Contractor will ensure attendance by appropriate staff at a regularly scheduled telephone conference call to discuss issues related to the external quality review program. During the conference calls, the Contractor will be expected to report the following:

a. EQRO activities undertaken during the period in review;

b. An explanation of any technical assistance provided to the Department or plan including the name(s) of the Department representatives and/or plan(s) involved and individuals providing consultation, as well as the nature of the assistance;

c. Status of reports due to the Department;

d. Any problems or issues found during the period in review.

The conference will not exceed two hours per call. The Contractor and the Department, at the inception of the contract, will mutually determine the time and frequency of the meetings.

Attendance at Departmental meetings is considered an administrative function necessary for performance of the scope of work. Accordingly, there will be no separate remuneration for costs associated with meeting attendance. Proposers will not be permitted to submit a bid, or invoices, for attendance at Departmental meetings.

H. Annual Work Plan

As a means to facilitate the coordination of EQRO activities between the Contractor and the Department, the Contractor is required to submit annual work plans prior to the beginning of each contract year. Specifically, a draft Annual Work Plan must be submitted to the Department no later than 60 days before the start of a new contract year. Based upon feedback from the Department, the Work Plan must be finalized by the end of the current contract year. For contract year one, the Contractor is expected to submit the initial Work Plan by November 1, 2002, or such later date as specified by the Department.

At a minimum, the Work Plan is to include identification of all EQRO activities and tasks planned for the contract year, as well as targeted timelines and completion dates for each activity.

Preparation of an Annual Work Plan is considered an administrative function necessary for performance of the scope of work. Accordingly, there will be no separate remuneration for costs associated with production of a work plan. Proposers will not be permitted to submit a bid, or invoices, for the Annual Work Plan.

I. Turnover/Phaseout Activities

During the last three months of the contract prior to expiration or termination, the Contractor will be required to perform all duties associated with the Turnover/Phaseout period as identified in Exhibit E. Turnover/phaseout activities are to include the delivery of documents, records, reports, and

databases, as required by the Department, to the Department or specified entity. Turnover/phaseout activities are considered an administrative function necessary for performance of the scope of work. Accordingly, there will be no separate remuneration for costs associated with turnover/phaseout activities. Proposers will not be permitted to submit a bid, or invoices, for these activities. Moreover, the Contractor must satisfactorily complete all turnover/phaseout activities before the final year's 10% withhold can be released.

J. Special Consultative Services

The Contractor may be asked to provide Special Consultative Services to assist the Department with activities undertaken as part of the Department's quality improvement strategy. Such Special Consultative Services are in addition to the activities described above in this scope of work. At the direction of the Department's Contracting Officer, the Contractor may be asked to conduct appropriate research on selected issues or propose strategies and methodologies for problem resolution or system improvement. Billing for Special Consultative Services will be based upon hourly consultative rates for specified professional classifications (e.g. Physician Consultant, Nurse Consultant, Actuary, Biostatistician, Epidemiologist; Information Technology Analyst; and Business Analyst).

All Special Consultative Services projects are to be short-term. Requests for special services requiring either permanent reporting changes or continuing developmental assistance must be processed though the State contracting amendment procedures.

All requests for Special Consultative Services will be transmitted in writing from the Department to the Contractor. Each request, at a minimum, will include:

a. A description of the major functions, tasks, and activities required;
b. The timeline/due date for any reports or identified deliverables;
c. Specifications as to the medium and/or format of the desired deliverable;
d. A listing of the Contractor's project requirements;
e. Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or products expected.

No Special Consultative Services will be approved without a written agreement that includes the minimum defined requirements as set forth above, as well as the agreed upon cost for completion of the project. The amount of payment will be based upon the professional classifications and number of hours agreed upon by the Contractor and the Department in accordance with the Contractor's approved hourly rates for personnel classifications contained in Attachment 10-2 (1-5) of this RFP.

The agreement must be signed by an authorized representative of the Contractor, as well as the Department's Contracting Officer before any work may begin. Any work initiated without written authorization will be deemed voluntary.

K. Reports

For each draft report, the Contractor is required to submit ten (10) copies, plus an electronic version on diskette. For each final report, the Contractor must send five (5) hard-copies and one (1) electronic copy. Additionally, the Contractor will be required to provide a camera-ready version of any final reports that will be mass produced for public distribution.

As a standard, the Department will submit comments regarding draft reports to the Contractor within 10 working days from receipt of the draft. Should the Department be unable to meet this timeframe, a new deadline for the final report may be negotiated at the Department's discretion. The Contractor is expected to notify the Department's Contracting Officer if comments regarding the draft report(s) are not received within the 10-day timeframe.

In the event that a final report does not meet the Department's satisfaction, the Department will exercise one of two options: (1) the Department will find the Contractor in default of its obligation to provide an acceptable final report and no payment shall be made to the Contractor for that report; or (2) the Contractor will be notified and will receive ten (10) working days to rectify the identified deficiencies and submit a revised report. If the Contractor does not meet the Department's requirements for reporting at that time, the Department will exercise option one.